but remains an employee of *Z* and is still eligible for coverage under *Z*'s group health plan.

(ii) *Conclusion.* In this *Example 2*, not later than October 1, 2010, the plan must provide *D* and *E* an opportunity to enroll (including written notice of an opportunity to enroll) that continues for at least 30 days, with enrollment effective not later than October 1, 2010.

Example 3. (i) *Facts.* Same facts as *Example 2*, except that *Z*'s plan had two benefit packages (a low-cost and a high-cost option). Instead of dropping coverage, *D* switched to the low-cost benefit package option.

(ii) *Conclusion.* In this *Example 3*, not later than October 1, 2010, the plan must provide *D* and *E* an opportunity to enroll in any benefit package available to similarly situated individuals who enroll when first eligible. The plan would have to provide *D* and *E* the opportunity to enroll in any benefit package available to similarly situated individuals who enroll when first eligible, even if *D* had not switched to the low-cost benefit package option.

Example 4. (i) *Facts.* Employer *Q* maintains a group health plan with a plan year beginning October 1 and ending September 30. For the plan year beginning on October 1, 2009, *Q* has an annual limit on the dollar value of all benefits of $500,000.

(ii) *Conclusion.* In this *Example 4*, *Q* must raise the annual limit on the dollar value of essential health benefits to at least $750,000 for the plan year beginning October 1, 2010. For the plan year beginning October 1, 2011, *Q* must raise the annual limit to at least $1.25 million. For the plan year beginning October 1, 2012, *Q* must raise the annual limit to at least $2 million. *Q* may also impose a restricted annual limit of $2 million for the plan year beginning October 1, 2013. After the conclusion of that plan year, *Q* cannot impose an overall annual limit.

Example 5. (i) *Facts.* Same facts as *Example 4*, except that the annual limit for the plan year beginning on October 1, 2009 is $1 million and *Q* lowers the annual limit for the plan year beginning October 1, 2010 to $750,000.

(ii) *Conclusion.* In this *Example 5*, *Q* complies with the requirements of this paragraph (e). However, *Q*'s choice to lower its annual limit means that under § 2590.715–1251(g)(1)(vi)(C), the group health plan will cease to be a grandfathered health plan and will be generally subject to all of the provisions of PHS Act sections 2701 through 2719A.

(f) *Applicability date.* The provisions of this section apply for plan years beginning on or after September 23, 2010. *See* § 2590.715–1251 of this Part for determining the application of this section to grandfathered health plans (providing that the prohibitions on lifetime and annual limits apply to all grandfathered health plans that are group health plans and group health insurance coverage, including the special rules regarding restricted annual limits).

[75 FR 37229, June 28, 2010]

§ 2590.715–2712 Rules regarding rescissions.

(a) *Prohibition on rescissions*—(1) A group health plan, or a health insurance issuer offering group health insurance coverage, must not rescind coverage under the plan, or under the policy, certificate, or contract of insurance, with respect to an individual (including a group to which the individual belongs or family coverage in which the individual is included) once the individual is covered under the plan or coverage, unless the individual (or a person seeking coverage on behalf of the individual) performs an act, practice, or omission that constitutes fraud, or unless the individual makes an intentional misrepresentation of material fact, as prohibited by the terms of the plan or coverage. A group health plan, or a health insurance issuer offering group health insurance coverage, must provide at least 30 days advance written notice to each participant who would be affected before coverage may be rescinded under this paragraph (a)(1), regardless of whether the coverage is insured or self-insured, or whether the rescission applies to an entire group or only to an individual within the group. (The rules of this paragraph (a)(1) apply regardless of any contestability period that may otherwise apply.)

(2) For purposes of this section, a rescission is a cancellation or discontinuance of coverage that has retroactive effect. For example, a cancellation that treats a policy as void from the time of the individual's or group's enrollment is a rescission. As another example, a cancellation that voids benefits paid up to a year before the cancellation is also a rescission for this purpose. A cancellation or discontinuance of coverage is not a rescission if –

(i) The cancellation or discontinuance of coverage has only a prospective effect; or

(ii) The cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

(3) The rules of this paragraph (a) are illustrated by the following examples:

Example 1. (i) *Facts.* Individual *A* seeks enrollment in an insured group health plan. The plan terms permit rescission of coverage with respect to an individual if the individual engages in fraud or makes an intentional misrepresentation of a material fact. The plan requires *A* to complete a questionnaire regarding *A*'s prior medical history, which affects setting the group rate by the health insurance issuer. The questionnaire complies with the other requirements of this part. The questionnaire includes the following question: ''Is there anything else relevant to your health that we should know?'' *A* inadvertently fails to list that *A* visited a psychologist on two occasions, six years previously. *A* is later diagnosed with breast cancer and seeks benefits under the plan. On or around the same time, the issuer receives information about *A*'s visits to the psychologist, which was not disclosed in the questionnaire.

(ii) *Conclusion.* In this *Example 1,* the plan cannot rescind *A*'s coverage because *A*'s failure to disclose the visits to the psychologist was inadvertent. Therefore, it was not fraudulent or an intentional misrepresentation of material fact.

Example 2. (i) *Facts.* An employer sponsors a group health plan that provides coverage for employees who work at least 30 hours per week. Individual *B* has coverage under the plan as a full-time employee. The employer reassigns *B* to a part-time position. Under the terms of the plan, *B* is no longer eligible for coverage. The plan mistakenly continues to provide health coverage, collecting premiums from *B* and paying claims submitted by *B*. After a routine audit, the plan discovers that *B* no longer works at least 30 hours per week. The plan rescinds *B*'s coverage effective as of the date that *B* changed from a full-time employee to a part-time employee.

(ii) *Conclusion.* In this *Example 2,* the plan cannot rescind *B*'s coverage because there was no fraud or an intentional misrepresentation of material fact. The plan may cancel coverage for *B* prospectively, subject to other applicable Federal and State laws.

(b) *Compliance with other requirements.* Other requirements of Federal or State law may apply in connection with a rescission of coverage.

(c) *Applicability date.* The provisions of this section apply for plan years beginning on or after September 23, 2010. *See* § 2590.715–1251 of this part for determining the application of this section to grandfathered health plans (providing that the rules regarding rescissions and advance notice apply to all grandfathered health plans).

[75 FR 37231, June 28, 2010]

§ 2590.715–2713 Coverage of preventive health services.

(a) *Services*—(1) *In general.* Beginning at the time described in paragraph (b) of this section and subject to § 2590.715–2713A, a group health plan, or a health insurance issuer offering group health insurance coverage, must provide coverage for all of the following items and services, and may not impose any cost-sharing requirements (such as a copayment, coinsurance, or a deductible) with respect to those items and services:

(i) Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force with respect to the individual involved (except as otherwise provided in paragraph (c) of this section);

(ii) Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved (for this purpose, a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention is considered in effect after it has been adopted by the Director of the Centers for Disease Control and Prevention, and a recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention);

(iii) With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration; and

(iv) With respect to women, to the extent not described in paragraph (a)(1)(i) of this section, evidence-informed preventive care and screenings